		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040998

Facility Name: Manorcare at Wilmette

Address: 432 Poplar Drive (Number) Wilmette (City) 60091 (Zip Code)

County: Cook

Telephone Number: (847) 256-5000 **Fax #** (847) 256-0225

IDPA ID Number: 520886946019

Date of Initial License for Current Owners: 06/12/95

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/00 to 05/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Barry Lazarus
(Title) Vice President - Reimbursement

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/00 Ending: 05/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	26	Skilled (SNF)	26	9,490	1
2		Skilled Pediatric (SNF/PED)			2
3	54	Intermediate (ICF)	54	19,710	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	29,200	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,063	2,543	2,751	8,357	8
9	SNF/PED					9
10	ICF	6,653	10,428	142	17,223	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,716	12,971	2,893	25,580	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.60%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/12/95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/12/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 2,586

Medicare Intermediary BCBS Maryland

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/01 Fiscal Year: 05/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/00 Ending: 05/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	241,394	16,569	(22,415)	235,548	1,076	236,624		236,624			1
2	Food Purchase		108,602		108,602		108,602	(853)	107,749			2
3	Housekeeping	92,054	10,433	67	102,554		102,554		102,554			3
4	Laundry		11,475		11,475		11,475	(6,809)	4,666			4
5	Heat and Other Utilities			100,357	100,357	4,935	105,292		105,292			5
6	Maintenance	43,717	6,189	(1,190)	48,716		48,716		48,716			6
7	Other (specify):*											7
8	**TOTAL General Services**	377,165	153,268	76,819	607,252	6,011	613,263	(7,662)	605,601			8
	B. Health Care and Programs											
9	Medical Director			12,600	12,600		12,600		12,600			9
10	Nursing and Medical Records	1,148,606	73,468	21,055	1,243,129	19,502	1,262,631		1,262,631			10
10a	Therapy	90,502	3,969	4,509	98,980		98,980		98,980			10a
11	Activities	52,798	(370)	4,962	57,390		57,390		57,390			11
12	Social Services	6,759			6,759		6,759		6,759			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,298,665	77,067	43,126	1,418,858	19,502	1,438,360		1,438,360			16
	C. General Administration											
17	Administrative	87,318		215,644	302,962	(41,894)	261,068		261,068			17
18	Directors Fees											18
19	Professional Services			17,014	17,014	(1,500)	15,514	(15,514)				19
20	Dues, Fees, Subscriptions & Promotions			79,619	79,619		79,619	(7,687)	71,932			20
21	Clerical & General Office Expenses	180,426	34,418	7,679	222,523	1,500	224,023	(45,006)	179,017			21
22	Employee Benefits & Payroll Taxes			278,383	278,383	(10,322)	268,061		268,061			22
23	Inservice Training & Education			490	490		490		490			23
24	Travel and Seminar			3,428	3,428		3,428		3,428			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			21,895	21,895		21,895		21,895			26
27	Other (specify):*											27
28	**TOTAL General Administration**	267,744	34,418	624,152	926,314	(52,216)	874,098	(68,207)	805,891			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,943,574	264,753	744,097	2,952,424	(26,703)	2,925,721	(75,869)	2,849,852			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Manorcare at Wilmette #0040998 Report Period Beginning: 06/01/00 Ending: 05/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			187,448	187,448	26,703	214,151		214,151			30
31	Amortization of Pre-Op. & Org.			14,970	14,970		14,970		14,970			31
32	Interest							(2,220)	(2,220)			32
33	Real Estate Taxes			212,982	212,982		212,982		212,982			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			9,286	9,286		9,286		9,286			35
36	Other (specify):*											36
37	**TOTAL Ownership**			424,686	424,686	26,703	451,389	(2,220)	449,169			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		54,609	15,981	70,590		70,590		70,590			39
40	Barber and Beauty Shops			9,103	9,103		9,103		9,103			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,800	43,800		43,800		43,800			42
43	Other (specify):*		15,045		15,045		15,045		15,045			43
44	**TOTAL Special Cost Centers**		69,654	68,884	138,538		138,538		138,538			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,943,574	334,407	1,237,667	3,515,648		3,515,648	(78,089)	3,437,559			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/00 Ending: 05/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(853)	2		4
5	Telephone, TV & Radio in Resident Rooms	(180)	21		5
6	Rented Facility Space	(46,600)	21		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(6,809)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,220)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,229)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(659)	21		16
17	Non-Care Related Fees	(188)	19		17
18	Fines and Penalties	3,150	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(15,326)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	3,512	21		24
25	Fund Raising, Advertising and Promotional	(7,687)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (78,089)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (78,089)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Manorcare at Wilmette

ID# 0040998

Report Period Beginning: 06/01/00

Ending: 05/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Wilmette # 0040998 **Report Period Beginning:** 06/01/00 **Ending:** 05/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(853)	0	0	0	0	0	0	0	0	0	0	(853)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(6,809)	0	0	0	0	0	0	0	0	0	0	(6,809)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(7,662)	0	0	0	0	0	0	0	0	0	0	(7,662)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(15,514)	0	0	0	0	0	0	0	0	0	0	(15,514)	19
20	Fees, Subscriptions & Promotions	(7,687)	0	0	0	0	0	0	0	0	0	0	(7,687)	20
21	Clerical & General Office Expenses	(45,006)	0	0	0	0	0	0	0	0	0	0	(45,006)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(68,207)	0	0	0	0	0	0	0	0	0	0	(68,207)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(75,869)	0	0	0	0	0	0	0	0	0	0	(75,869)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Manorcare at Wilmette** **#** **0040998** **Report Period Beginning:** **06/01/00** **Ending:** **05/31/01**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,220)	0	0	0	0	0	0	0	0	0	0	(2,220)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,220)	0	0	0	0	0	0	0	0	0	0	(2,220)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(78,089)	0	0	0	0	0	0	0	0	0	0	(78,089)	45

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/00 Ending: 05/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ManorCare, Inc.	100	Health Care & Retirement Corporation of America (SEE H.O. COST REPORT)	Toledo, OH			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		See Page 8	Home Office Allocation	$ 215,644	HCR Manor Care, Inc.	100.00%	$ 215,644	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V		10a	Therapy Management	751	Heartland Management Services	100.00%	751		6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 216,395			$ 216,395	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/00 Ending: 05/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/00 Ending: 05/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR ManorCare, Inc
Street Address: 333 North Summit St.
City / State / Zip Code: Toledo, OH 43604
Phone Number: (419) 252-5500
Fax Number: (419) 254-5495

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	$	$		$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	671,002	407,536	3,314,854	1,076	2
3	5	Utilities - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	262,823		3,314,854	480	3
4	5	Utilities - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	2,777,349		3,314,854	4,455	4
5	10	Nursing - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	6,096,791	4,282,378	3,314,854	11,127	5
6	10	Nursing - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	5,221,432	3,383,186	3,314,854	8,375	6
7	17	General & Admin - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	23,025,730	19,694,773	3,314,854	42,022	7
8	17	General & Admin - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	82,128,599	31,955,235	3,314,854	131,728	8
9	22	Employee Benefits - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	2,724,065		3,314,854	4,972	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	(9,534,453)		3,314,854	(15,294)	10
11	30	Depreciation - Direct	Accumulated Cost	1,816,305,362	357 Nurs. Fac.	74,480		3,314,854	136	11
12	30	Depreciation - Pooled	Accumulated Cost	2,066,722,869	357 Nurs. Fac.	16,563,680		3,314,854	26,567	12
13										13
14	32	Interest		0		14,161,817			0	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 144,173,315	$ 59,723,108		$ 215,644	25

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/00 Ending: 05/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8								Interest Income			(2,220)	8
9	TOTAL Facility Related						$	$			$ (2,220)	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ (2,220)	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/00 Ending: 05/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 183,278	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 183,278	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 212,982	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 212,982	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	172,243	8
	1997	179,204	9
	1998	204,948	10
	1999	183,278	11
	2000	212,982	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare at Wilmette COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040998

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-34-121-041-0000	See Attached	$ 4,491.31	$ 4,491.31
2.	05-34-121-042-0000	See Attached	$ 3,111.73	$ 3,111.73
3.	05-34-121-048-0000	See Attached	$ 5,580.08	$ 5,580.08
4.	05-34-121-050-0000	See Attached	$ 3,851.95	$ 3,851.95
5.	05-34-121-051-0000	See Attached	$ 4,159.86	$ 4,159.86
6.	05-34-121-056-0000	See Attached	$ 191,787.33	$ 191,787.33
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 212,982.26	$ 212,982.26

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/00 Ending: 05/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,881 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1995	$ 500,819	1
2					2
3	TOTALS			$ 500,819	3

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/00 Ending: 05/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	80		1995	1969	$ 661,737	$ 16,543		$ 16,543	$	$ 68,707	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BUILDING IMPROVEMENTS (Current Year Depreciation)					57,426		57,426		198,601	9
10				1983	7,273						10
11				1985	17,043						11
12				1988	1,961						12
13				1989	7,178						13
14				1990	20,800						14
15				1991	2,428						15
16				1992	34,209						16
17				1993	55,467						17
18	INSTALL GARBAGE DISPOSAL/EJECTORS			1995	1,726						18
19	STORAGE TANKS			1995	7,303						19
20	PAINTING			1995	2,355						20
21	FLOOR/WALL TILE			1995	1,643						21
22	VERTICLE VESSELS			1995	21,838						22
23	CARPET CLEANING			1996	1,197						23
24	CAPITALIZED LABOR			1996	4,074						24
25	SIGN			1996	162						25
26	ELECTRICAL			1996	181,279						26
27	GENERAL REQUIREMENTS			1996	110,589						27
28	FLOORING/CEILING			1996	75,391						28
29	ARCHITECT/ENGINEER/LEGAL FEES			1996	52,531						29
30	CARPENTRY/MASONRY			1996	35,295						30
31	MILLWORK			1996	17,943						31
32	DOOR & WINDOW FRAMES			1996	26,753						32
33	FINISH STUD/DRYWALL			1996	8,964						33
34	PAINTING/WALLCOVERINGS			1996	28,690						34
35	PLUMBING			1996	63,189						35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/00 Ending: 05/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	HVAC	1996	$ 22,253	$		$	$	$	37
38	CORNER GUARDS	1996	4,423						38
39	NURSE CALL STATION	1996	32,513						39
40	LIGHTING	1996	15,386						40
41	PERMITS	1996	4,646						41
42	CORPORATE OVERHEAD	1996	86,993						42
43	TRAVEL/DELIVERY	1996	13,507						43
44	SIGNS	1996	2,875						44
45	KICKPLATES	1996	1,697						45
46	CABLE/WIRING	1996	2,218						46
47	CARPET	1996	37,911						47
48	WALLCOVERINGS	1996	30,453						48
49	NEW COIL	1996	6,413						49
50	PIPING/INSULATION	1996	10,765						50
51	PUMP UPGRADE	1996	2,639						51
52	RANGE GUARD	1996	1,649						52
53	NURSE CALL SYSTEM	1997	7,208						53
54	ARCHITECT/ENGINEER FEES	1997	3,491						54
55	GENERAL CONTRACTOR	1997	21,640						55
56	FURNISH & INSTALL HEATER	1997	5,109						56
57	REPLACE DOORS/ALARM	1997	2,957						57
58	REPLACE WATER LINE	1997	2,423						58
59	CORPORATE OVERHEAD	1997	10,516						59
60	SITE PREP/LANDSCAPE	1997	11,180						60
61	FLOORING	1997	916						61
62	ROOFTOP A/C	1997	39,990						62
63	FACILITY PLAN ALLOC	1997	5,964						63
64	INSTALL NEW SUNROOM	1997	59,481						64
65	ASBESTOS REMOVAL	1997	19,675						65
66	ELECTRICAL	1997	4,156						66
67	ROOF WORK	1997	1,129						67
68	VINYL SHED	1997	803						68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,921,997	$ 73,969		$ 73,969	$	$ 267,308	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/00 Ending: 05/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,921,997	$ 73,969		$ 73,969	$	$ 267,308	1
2	ELECTRICAL	1998	17,790						2
3	PAINTING/ROOF/SIDING/CONCRETE	1998	20,304						3
4	BEAMS/STEEL	1998	4,320						4
5	CARPENTRY	1998	4,532						5
6	GENERAL CONTRACTOR FEES	1998	4,416						6
7	CARPET	1998	4,767						7
8	REMOVE & INSTALL DIFUSERS/DUCTS	1998	1,865						8
9	INSTALL DOORS	1998	4,466						9
10	CORPORATE OVERHEAD	1998	1,651						10
11	ENIGNEER/ARCHITECT FEES	1998	1,539						11
12	PLUMBING	1998	11,963						12
13	ELECTRICAL	1998	4,659						13
14	DEVELOPERS	1998	5,555						14
15	HVAC	1998	9,751						15
16	SIGN	1998	14,116						16
17	ROOFING	1998	3,725						17
18	PAINTING/WALLCOVERING	1999	1,418						18
19	FLOORING/CEILING	1999	3,964						19
20	HVAC	1999	6,727						20
21	DOOR/WINDOW	1999	2,938						21
22	ROOFING	1999	6,915						22
23	ARCHITECT	1999	15,472						23
24	PAVING	1998	17,975						24
25	KICKPLATES, HANDRAILS	1999	2,938						25
26	REMOVE OLD BOILER	1999	980						26
27	BUILDING DECORATIONS	1999	4,680						27
28	A/C UPGRADE	1999	17,360						28
29	BOILER CONTROLS	1999	23,650						29
30	ENGINEERING SERVICE	1999	779						30
31	VWC RES RMS/CORRIDORS	2000	8,025						31
32	ACCESS PANEL/AC UNIT	2000	520						32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,151,757	$ 73,969		$ 73,969	$	$ 267,308	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/00 Ending: 05/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,151,757	$ 73,969		$ 73,969	$	$ 267,308	1
2	AIR CONDITIONING UNIT	2000	4,121						2
3	ROOF REPAIRS	2000	1,065						3
4	EVELATOR UPGRADE	2000	590						4
5	CIRCUIT BOARD - FIRE ALARM	2000	2,461						5
6	ROOF INSPECTION	2001	650						6
7	INJECTOR PUMP	2001	2,697						7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,163,340	$ 73,969		$ 73,969	$	$ 267,308	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/00 Ending: 05/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 907,585	$ 113,479	$ 113,479	$		$ 574,528	71
72	Current Year Purchases	32,425						72
73	Fully Depreciated Assets							73
74	H/O Allocation			26,703	26,703			74
75	TOTALS	$ 940,010	$ 113,479	$ 140,182	$ 26,703		$ 574,528	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,604,169	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 187,448	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 214,151	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 26,703	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 841,836	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 9,286 Description: 02 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, Etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/00 Ending: 05/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	1644 hrs	$ 34,090	14	$ 285	$ 305	1,658	$ 34,680	1
2	Licensed Speech and Language Development Therapist	10a	301 hrs	6,233	186	3,856	22	487	10,111	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	2419 hrs	50,179	18	368	541	2,437	51,088	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				54,609		54,609	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): P/S Pharm, Lab	39,3				15,981	3,101		19,082	13
14	TOTAL			$ 90,502	218	$ 20,490	$ 58,578	4,582	$ 169,570	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Wilmette # 0040998 **Report Period Beginning:** 06/01/00 **Ending:** 05/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 05/31/01 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 26,447	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (114,491))	517,610		3
4	Supply Inventory (priced at)	3,163		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,747		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 549,967	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	500,819		13
14	Buildings, at Historical Cost	2,163,340		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	940,010		16
17	Accumulated Depreciation (book methods)	(841,836)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,762,333	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,312,300	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 15,940	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	197,261		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	212,982		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	36,565		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 462,748	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 462,748	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,849,552	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,312,300	$	48

***(See instructions.)**

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/00 Ending: 05/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 6,096,541	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 6,096,541	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	318,053	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 318,053	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(3,565,042)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (3,565,042)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,849,552	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/00 Ending: 05/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,222,776	1
2	Discounts and Allowances for all Levels	(798,252)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,424,524	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	287,562	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 287,562	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	659	12
13	Barber and Beauty Care	11,539	13
14	Non-Patient Meals	194	14
15	Telephone, Television and Radio	180	15
16	Rental of Facility Space	46,600	16
17	Sale of Drugs	52,261	17
18	Sale of Supplies to Non-Patients	1,153	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	6,809	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 119,395	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,220	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,220	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,833,701	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	607,252	31
32	Health Care	1,418,858	32
33	General Administration	926,314	33
	B. Capital Expense		
34	Ownership	424,686	34
	C. Ancillary Expense		
35	Special Cost Centers	138,538	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,515,648	40
41	**Income before Income Taxes (line 30 minus line 40)****	318,053	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 318,053	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/00 Ending: 05/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,584	2,888	$ 77,268	$ 26.75	1
2	Assistant Director of Nursing	819	915	19,203	20.99	2
3	Registered Nurses	17,740	19,827	275,133	13.88	3
4	Licensed Practical Nurses	21,252	23,753	251,486	10.59	4
5	Nurse Aides & Orderlies	64,014	71,547	510,159	7.13	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,854	4,364	90,502	20.74	7
8	Rehab/Therapy Aides					8
9	Activity Director	5,443	6,094	52,798	8.66	9
10	Activity Assistants					10
11	Social Service Workers	461	521	6,759	12.97	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,365	21,634	241,394	11.16	15
16	Dishwashers					16
17	Maintenance Workers	2,649	2,972	43,717	14.71	17
18	Housekeepers	8,289	9,273	92,054	9.93	18
19	Laundry					19
20	Administrator	2,383	2,080	87,318	41.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,496	13,496	180,426	13.37	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,510	1,679	15,357	9.15	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	163,859	181,043	$ 1,943,574 *	$ 10.74	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 2,753	5,1,3	35
36	Medical Director	Monthly	12,600	5,9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	4,962	5,11,3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 20,315		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	1,520	16,097	5,10,3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,520	$ 16,097		53

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/00 Ending: 05/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Char Adams	Administrator	0	$ 14,553
Tim Irwin	Administrator	0	72,765
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 87,318

B. Administrative - Other

Description	Amount
Management Fees	$ 215,644
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 215,644

C. Professional Services

Vendor/Payee	Type	Amount
	Legal Fees	$ 15,326
	Accounting Fees	188
	Professional Fees	1,500
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 17,014

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 19,644
Unemployment Compensation Insurance	14,435
FICA Taxes	145,791
Employee Health Insurance	81,003
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	1,635
Payroll Overhead Allocated	0
401K / SMSP Match	10,979
Other Employee Benefits	4,365
Employee Uniforms	531
Home Office Allocation	(10,322)
TOTAL (agree to Schedule V, line 22, col.8)	$ 268,061

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 710
Advertising: Employee Recruitment	16,508
Health Care Worker Background Check (Indicate # of checks performed 50)	1,001
Dues & Subscriptions	884
Association Dues	3,150
Advertising	56,990
Public Relations	376
Less: Public Relations Expense	(376)
Non-allowable advertising	(7,311)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 71,932

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,428
Includes travel expense to the Home Office in Toledo, OH for regional meeting	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,428

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/00 Ending: 05/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
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8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Manorcare at Wilmette # 0040998 Report Period Beginning: 06/01/00 Ending: 05/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $ 3150**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? _____

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **27,694** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **43,800**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **(194)**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.